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INTERPERSONAL RELATIONSHIPS IN THE PHYSIOTHERAPY CLINICAL SETTING

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This paper consists of an introductory review of a limited portion of the literature pertaining to interpersonal relationships. As it placed particular emphasis on therapist-patient relationships, and their development in physiotherapy clinical affiliations, particular attention has been paid to aspects such as interpersonal communication and perception, observational learning, feedback and reiforcement. It appears that attempts to teach interpersonal relationship skills, although providing some positive results, are still far from efficient, and in fact the development of such programmes is still in its infancy. However interest in this area is growing and future contributions to its development are anxiously awaited by many.

THE PHYSIOTHERAPY CLINICAL AFFILIATION AT CUMBERLAND COLLEGE

Students in the degree programme in physiotherapy encounter their first clinical affiliation at the end of the third semester of the course. By this time they have completed their study of anatomy and the basic sciences, and are well advanced in their study of physiology and behavioural science subjects (psychology, sociology and measurement). They have embarked upon the initial study of pathology and traumatology, therapeutics, kinesiatrics and electrotherapy and so have a limited physiotherapeutic background for their first affiliation. They are supervised by qualified therapists, usually at up to a 6:1 student-staff ratio.

Understandably, therefore, the students exhibit high levels of anxiety, and low levels of self-confidence in their abilities as therapists, in their initial patient encounters, which impedes the development of a good interpersonal relationship with the patient. Some students have added difficulties in coping with patients with low levels of motivation to improve their function, with different levels of intelligence, and with different social and/or ethnic backgrounds. These difficulties, however, are balanced by extremely high student motivation to treat each patient effectively, and to develop expertise as a therapist. These observations are based on student discussions both before and after the first clinical affiliation.

Besides these difficulties, the student must learn to cope with the bureaucratic organization within which they must now work. This is seen by the students often as frightening, frequently as restrictive after the comparative freedom of college life, and at times as a shield to hide behind in moments of uncertainty – all of which are hindrances to the development of balanced student-patient relationships.

Finally another difficulty to be overcome is the preconceived ideas which the student may have of the clinical supervisor. This may vary greatly depending upon a student's previous knowledge of the supervisor. Many students see their supervisor as a threatening being whose major function is to criticize. Other students see their supervisor as a supportive person, who will alsway be there so that mistakes can never happen, and who is therefore a replacement for their lack of confidence and initiative. It appears, however, that the student comes to recognise that the supervisor will act as critic, assistant, adviser, comforter and will encourage discussion, individuality and enthusiasm as each different situation requires. Again, these observations are based on student discussion.

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Purtilo (1973) categorizes the skills to be acquired by a student in a health profession as motor skills (safe, effective techniques), interpersonal relationship and communication skills, teaching and administrative skills, and research skills. She adds that the student must also acquire knowledge and attitudes which reflect how the student will react in a given situation. Thus personal qualities such as caring for others, and professional qualities such as competence, objectivity and efficiency, should be integrated into one set of complementary qualities.

The questions then arise:

to what extent can students be taught about the development of student-patient relationships at an academic level prior to the clinical affiliation?

to what extent can the student-clinical supervisor relationship be more clearly defined for the student in meaningful terms prior to the clinical affiliation?

THE STUDENT-PATIENT RELATIONSHIP

Carkhuff (1969) states that "the goals of all helping processes involve (1) understanding the physical, emotional and intellectual world, and (2) being able to act upon and develop this world." These general goals require clarification.

Shaw & Gath (1975) quote Rogers as having stated that in professional work involving relationships with people it is the quality of the encounter with the patient which is most significant in determining effectiveness. Individuals very different in personality, orientation and procedure can all be successful in a helping relationship. He states that the therapist should be genuine, openly showing feelings and attitudes, and communicating these, if appropriate. Thus the therapist should be able to experience an accurate emphatic understanding of the patient's world, and to communicate this understanding. He states further that the therapist must experience a warm, positive, acceptant attitude, or positive regard, towards the patient as a person, caring in a non-possessive way. This feeling should not have reservations or be evaluated by the therapist. He rightly reminds us that these attitudes must also be perceived by the patient. However, ". . . when confronted with a patient for the first time, a student may find himself reacting in many different ways . . . There are as many responses as student-patient situations, frequently complex, upsetting and worrying . . . Patients also will react in differing ways to the student." (Shaw & Gath, 1975 : 178).

Gardiner (1967) describes the characteristics most frequently cited as being desirable in the psychotherapeutic relationship, as warmth, acceptance, permissiveness, respect for the patient, understanding, interest in the patient, and liking for the patient. She also states that the patient must be able to perceive these qualities and must like and respect the therapist. Gardiner does not relate acquisition of these attitudes to scholastic achievement, but suggests that it is probably a function of actual experience in the counselling clinical situation, although personal commitment to the significance of helping relationships may be a more pertinent variable. Gardiner also states that the motivation of the patient for therapy, the capacity for friendliness, dependency, ethical values and social class all increase the quality of therapeutic relationship.

Purtilo (1973) discusses the relationship between the allied health professional and the patient in some detail, claiming that care for the patient can be expressed by maintaining distance as well as by creating closeness. It may be effective to mention personal topics to remind the patient of the real situation between the therapist and the patient. However a display of pity may be destructive and belittling to the patient, and the therapist should recognize problems which should be referred to others, for example the social worker, who may be able to help. Thus the therapist may be creating distance by bringing others into the relationship, but by doing so may also be showing a caring attitude.

Overidentification with the patient should be avoided by initially restricting communication to a more impersonal level, giving the patient the opportunity to describe, full his or her unique experiences. Then, as the therapist describes his or her ideas and judgements, the patient may recognise the description of the therapists's own experience as revealing concern and insight into the patient's problem. "Wisdom and tact are certainly needed to prevent a warm interaction from being destroyed by hopeless infatuation, pity or overidentification." (Purtilo, 1973).

Purtilo points out that professional closeness is not just a casual or informal approach, for example the use of first names, but neither is it an intimate entanglement in the patient's interests and problems. It does not consist only of reassurance, although this is vital to it, and it does occur automatically. It is based on mutual respect and dignity. The relationship is limited by the setting, for example bedside or treatment area, wearing of uniforms, and the ability to perform a health care service need by the patient; and it is limited by time. Therefore the therapist should give the impression of having plenty of time, give equal time to the

needs of each patient and avoid interruptions, without allowing overdependence by allowing the patient to define the time limits.

Purtilo recommends that therapists reveal themselves to their patients by defining their position in the relationship rather than exchanging irrelevant personal information or displaying uncontrolled emotion, by revealing their own personality, and by making patients aware of the behaviour expected of them by giving consistent and honest responses to patient actions. Patients may be assisted to reveal themselves to their therapist by the therapist recognizing that the patient has an emotional or feeling-level problem (fear, anger, hurt, embarrassment). By the therapist telling the patient the emotion that appears to be expressed, by allowing the patient to express true emotions verbally without reacting by showing shock or disapproval, and by allowing the patient to do most of the talking, especially about personal activities. The patient needs to trust the therapist enough to know that he or she will not be ridiculed or betrayed as a result of the expression of true feelings. He or she also needs to know that the therapist will help without being completely overcome by his or her own feelings.

Thus Purtilo has detailed the therapist-patient relationship as it would apply in the physiotherapy setting. Diedrich (1974), however, looks at therapy as having the following topographical dimensions:

(a) structural: referring to the selection and use of materials, equipment and procedures;

(b) spatial: referring to the arrangement of furniture, materials and the people involved;

(c) postural and gestural;

(d) extra-verbal: referring to the use of vocal pitch and expressions such as "uh-huh" and "mm";

(e) verbal: referring in particular to the appropriateness of language;

(f) temporal: referring to the timing of the stimulus-response sequence;

(g) behavioural: referring to the motivation of the patient and the therapist and to their responses to one another;

(h) psychological: referring to the sensitivty of the therapist to the patient's needs, and the development of rapport and confidence.

There are several areas in which the ideas of Purtilo of Diedrich overlap, but many other areas where a combination of both views would perhaps lead to a more complete description of the therapist-patient relationship.

The aspects of the relationship described, however, fail to examine the importance of communication and of perception in any interpersonal relationship. Therefore these topics will be discussed separately in some detail.

INTERPERSONAL COMMUNICATION

Hayes & Larsen (1963) summarise supportive interpersonal communication techniques which may be used in interaction with patients. An interested, expectant silence may convey to the patient that he or she is expected to initiate communication. The therapist, by indicating a desire to understand, and giving broad openings such as "Is there something you'd like to talk about?" may stimulate the patient to take the initiative. The patient may then be encouraged to continue by being given an indication of reception, using general leads which keep the verbal activity of the therapist at a minimum, for example "Go on," or by nodding.

The patient may be assisted in communicating by the therapist clarifying the relationship of events in a true sequence, and by encouraging the patient to describe what is perceived, such as "You appear tense", so that mutual understanding of the behaviour may be obtained by discussion. Comparison with other experiences may clarify similarities or differences for the patient. Repeating the main idea expressed allows the patient to recognize that understanding exists. It is also important to indicate that it is the patient's point of view which is important. At times it may be necessary to focus on a single point to convey its importance, or when the patient shifts rapidly from one point to another.

The therapist may wish to explore a point further, however if this is resisted by the patient the therapist must respect this desire. The therapist must also be prepared to give the patient information that is needed. This builds trust and may help the patient to clarify some of the problems. At times it may be necessary to express doubt as to the reality or accuracy of the patient's perceptions, or to clarify that both patient and therapist are using the same words to convey the same meaning. The therapist may need to verbalize something which the patient has inferred by a hint or suggestion, in order to encourage further discussion. The patient should be encouraged to evaluate personal experiences rather than unquestioningly adopt the opinions and values of others.

Perhaps most important in the sequence of the communication are the final stages. The therapist should summarize the communication, omitting any irrelevancies and organizing the pertinent points logically. The therapist should offer an indication of a desire to work together with the patient for his or her benefit. The patient should be encouraged to contribute to the formulation of an appropriate form of action.

Thus, Hayes & Larsen (1963) have described supportive communication techniques. It is equally important, however, to examine the area of non-supportive techniques. Hayes & Larsen have summarized these as including the following techniques. Reassurance may indicate the therapist's lack of understanding or inability to place some value on the patient's judgment unless the reassurance can be justified. Approval of the patient's ideas or behaviour may limit the patient's freedom to think or act and direct him or her to behave in a manner which will gain praise rather than the desired progress. Similar responses will be obtained by the therapist rejecting the patient's ideas or behaviour, or by indicating disapproval. Giving advice, without allowing the patient opportunity for self-direction, persistent questioning and challenging the patient about ideas may reduce the patient's feeling of value. Defending something the patient has criticized may imply that such feelings or opinions should not be expressed. Belittling the feelings expressed by the patient, making stereotyped responses, refusing to admit that a problem exists, ignoring and arguing are further examples of non-supportive techniques of communication.

There are, however, a number of factors which complicate interpersonal communication and some of these are found to exist in an extreme form in medical settings. Barnlund (1976) suggests that these include factors such as ego-involvement, differences in knowledge, social status, communicative purposes, emotional distance, one-way communication, verbal manipulation, ambiguity of language, use of jargon and pressure of time. Barnlund suggests that these factors are present in most doctor-patient encounters in their most extreme and destructive form. He states:

> "It is here that emotionally disturbing matters, sometimes of life and death, are discussed. It is here that the immense authority and power of one communicant faces the ignorance and impotence of the other. It is here that the need for rapport is the largest, yet the emotional distance is likely to be greatest. It is here, too, that critical choices must be made with information which is clothed in an esoteric jargon that obscured and mystifies. And it is here that words are uttered rapidly, even unintelligibly, with little time to clarify or assimilate their meaning. Some of these obstacles are inherent in illness itself: some derive from the historical roles of physician and patient; others result from the personal communicative style of the physician or are a matter of cultivation by the medical profession." (p.721).

This situation is also possible in the therapist-patient relationship. Hence the growing concern and gradual recognition of the need to teach interpersonal relationship skills as a component of the total education programme.

INTERPERSONAL PERCEPTION

Hastorf *et al* (1973) state that ". . . perception is not the passive translation of physical energies into experience but is a process demanding active participation by the perceiver. He selects and categorizes, he interprets and infers to achieve a meaningful world in which he can act." (p.181). He also states that ". . . we perceive other people as causal agents, we infer intentions, we infer emotional states, and we go further to infer enduring dispositions or personality traits." (p.181). Heidler (1969) states that ". . . persons are perceived as having abilities, as acting purposefully, as having wishes or sentiments, as perceiving or watching us." (p.22). He suggests that we recognise a person's traits, wishes, sentiments or intentions from what is done and said.

Perceiving, thinking and feeling occur on both sides and are dependent upon one another. Thus Heidler (1969) suggests that a person can be the agent or active role in purposeful behaviour; or the person may be the recipient or passive role, undergoing or suffering, whose satisfactions or frustrations are the goals of another person. He suggests that perception is determined by the function of representation, and that perception and representation then lead to control over the part of the environment represented, to evaluation, and to communication between persons. These factors will then determine the reaction to being perceived and whether the perceived should have a more complete representation of ourselves or not.

Newcomb (1969) states that ". . . an individual tends to be attracted to others who are seen as viewing as important the same things that he himself regards as important, and as taking attitudes towards them that are similar to his own." (p.180). Initially attraction is more closely related to perceived than to actual agreement, then, given opportunity for assoc-

iation and communication, judgments tend to become more accurate. Perceived attitudes tend to promote interpersonal integration and to reduce conflict and strain.

These authors confirm the previously stated concept the communication and perception are of major importance in any inter-personal relationship.

Having determined the various facets of the student-patient (or therapist-patient) relationship, we must now search for methods of teaching the relationship to the student. Ideally, it would be desirable to discover methods of teaching which could be implemented prior to the initial student-patient contact, as well as methods which utilize this contact.

TEACHING THE THERAPIST–PATIENT RELATIONSHIP

Many studies summarised by Pace *et al* (1976), have been undertaken to determine the effects of various teaching methods on the development of the Therapist-Patient and Doctor-Patient Relationship. "They include student interviews followed by discussion, usually in a group aided by audio or video recording, the interpersonal process recall method, microcounselling, videotaped interviewing with actors simulating patients, first-year medical students working in a closely supervised programme in an outpatient clinic, multiple techniques ranging from role-playing and programmed manuals to the observation of films of experienced interviewers, and, finally, practice interviews and group discussion to reduce emotional distance between physician and patient."
(Pascoe *et al* 1976 : 743).

One such study (Bonito & Levine, 1975) suggests that the factors which influence the development of professional attitudes in medical students appear to vary and ". . . include socialization influences, self-selection, and generalization effects." (p.25).

Pascoe *et al* (1976) have enumerated several important features which should be common to any attempt to teach interpersonal relationship skills. They are that: ". . . (a) the essential elements of relationship skills are isolated, defined, and systematically taught; (b) the students practice the skills in either simulated or actual interpersonal situations; (c) immediate feedback on student performance is given; (d) training takes place in relatively small groups in order to individualize instruction; and (e) the dynamics of group process are utilized to provide both support and stimulation for learning." (p.748).

The most notable factor derived from the study by Stritter *et al* (1975) was ". . . the students' desire to be an active participant in the learning process, which reflects their concern about the more typical teacher domination of the process." (p.880). This finding suggests that students would be better satisfied by the teaching approach described by Pascoe *et al.*

A study of nurse-patient relationships conducted by Bernstein *et al* (1954) ". . . concluded that the nurses' skills and attitudes in interpersonal relationships can be modified in a significant fashion when nurses understand the nature of the techniques they use, the attitudes which such techniques express or implement, and the feelings they generate in patients." (p.84). The use of programmed instruction, with some classroom discussion and bibliography readings, significantly effected the human relations skill of the nurses participating in the project. The programme was also said to have helped these nurses with their roles both as team members and team leaders. (Currey *et al*, 1968 : 459).

Carkhuff (1969(states that ". . . constructive or destructive consequences in training may be accounted for in large part by the initial level of functioning of both trainer and trainee on dimensions related to constructive change." (p.149). He suggests that ". . . the most effective programmes appear to be those that (1) focus upon primary facilitative and action-oriented dimensions complemented by secondary dimensions involving preferred modes of treatment and (2) integrate the didactic, experiential, and modelling aspects of learning." (p.150). Carkhuff recommends that the trainer should be experienced in the areas, and should also have demonstrated a level of expertise or excellence, as the level of the trainer's functioning appears to be the single most critical aspect of effective training. Carkhuff also states, however, that ". . . some individuals can deliver and some cannot. Those who cannot deliver must be trained; those who cannot be trained must be treated; those who can be neither trained nor treated must not hold positions of responsibility in the area of human relations." (p.289).

Rather than continuing to investigate attempts to teach all aspects of the therapist-patient relationship this study will now concentrate on methods of assisting development of empathy. Although this is only one aspect of the relationship, it is one of concern to clinical educators and serves as an example of the difficulties encountered in teaching interpersonal relationship skills.

THE DEVELOPMENT OF EMPATHY

Kuhmerker (1975) listed the following definitions. Freud (1949) defined empathy as "the mechanism by means of which we are enabled to take up any attitude at all toward another mental life: Mead (1934) described empathy as ". . . the essence of social intelligence: and felt that ". . . the practice of role-taking led to social sensitivity and the emergence of a self-concept and self-control." Fenichel (1945) stated that " . . . empathy involved both an identification with another person and an awareness of the feelings of the object identified becomes possible." Kuhmerker states that studies on empathy have been inconclusive, partly due to lack of specific definition of empathy, and also due to poor construct validity when these definitions are operationalized.

Some recent studies (for example, Hoffman, 1975) suggest that human beings have an innate capacity for empathy, but that empathy is developed in childhood by exposure to normal experiences including those high in emotion. It is suggested then, that children should be encouraged to take roles, help others and receive corrective feedback. Kuhmerker (1975), Selman (1975) suggests that empathy may be considered as an ability which develops at some point in time, correlates with other social and cognitive processes and behaviours, and is influenced by certain experiences. Alternatively, Selman suggests that it may be a primary human phenomenon and should be studied in terms of the developing forms it takes in natural age-related development.

Although this indecision about both the definition and development of empathy continues to exist, some attempts have been made to develop empathy in workers in the "helping professions." Carkhuff (1969(suggests that such training should concentrate on the interchangeability of the communications of patient and therapist, in that such communications should express essentially the same affect and meaning, feeling and content. For this to be maximised there must be intense concentration on the patient's expressions; the therapist must use language to which the patient is attuned; and the therapist should use the patient's behaviour to assess the effectiveness of his responses. Carkhuff advocates the use of role-playing in an attempt to involve the student in lifelike experiences, and allows the student to experience being in need of help as well as helping.

Kalisch (1971) constructed a programme for the development of empathy in nursing students. The programme consisted of discussions of the concept of empathy, discrimination training, communication practice, role-playing, the use of the teacher as a role model of empathy, and finally the experiential component consisting of the "empathic, caring, authentic relationship with the teacher." Evaluation of this programme indicated that it was successful, though not totally adequate. Gains in the level of empathy, as assessed by students and clinical instructors, were achieved and maintained at a six-week follow-up assessment. There were no gains, however, demonstrated on a patient-evaluation of student empathy.

Although most studies agree as to the components of a programme designed to develop empathy, the implementation of these programmes appears to have restricted effect. Whether this is due to the problems of definition and operationalizing the definition, or whether the problem lies in the content of the programmes and the methods of their evaluation is not clear.

In the phsysiotherapy clinical situation, however, the student-supervisor relationship is also of importance. This study will now examine some aspects of this relationship.

THE STUDENT–SUPERVISOR RELATIONSHIP

Bigge (1971) describes three types of relationships. In the authoritarian relationship the supervisor exerts firm, centralized control and directs student actions and thoughts. In the *laissez-faire* relationship the supervisor does not lead at all, letting the students follow their own initiative, whilst being prepared to answer questions. In the democratic relationship the supervisor leads in the discussion of ideas and encourages students to think for themselves. Carlisle (1973) describes this leadership style as remaining constant over a long period of time, but leadership behaviour may deviate from the general pattern on occasions, for example, fits of anger or mood fluctuations. Leadership style may also be varied under certain circumstances, such as the democratic leader becoming authoritarian in emergency situations; or the laissez-faire leader becoming authoritarian if the leadership position or the goals of the organization are threatened.

Another aspect of the relationship which may be considered important is the so-called "generation gap". Bengston & Black state that 'Relations between generations are seen as a continuous bilateral negotiation in which the young and the old exchange information and influence from their respective positions in developmental and historical time. There are inevitable intergenerational differences, stemming from contrasting types of contact with

cultural institutions, differences in orientation towards future time, age differentials in social position, and within cohort solidarity. There are also inevitable intergenerational similarities, resulting from interdependence, explicit attempts at transmission, and mutual effect-informational dependence." (p.209). Some of these aspects are appropriate to some student-supervisor relationships, if not in the eyes of the supervisor, then certainly in the eyes of the student.

The research on pupil-teacher relationships in schools shows that students prefer a teacher who keeps good control, is fair, has no favourites, gives no extreme or immoderate punishments, explains and helps, gives interesting lessons, is cheerful, friendly, patient, understanding, has a good sense of humour, and takes an interest in the students as individuals, (Hargreaves, 1972). This is a high standard for the clinical supervisor to meet but it is seen as being relevant as a large proportion of learning takes place, particularly in the development of interpersonal relationship skills, as a result of observational learning with the supervisor as the model. However di Vesta & Thompson (1970) point out that the selection of the teacher as the model is also influenced by the individual's prestige in the chosen field, success in that field, and the fact imitation is possible.

OBSERVATIONAL LEARNING

Bronfenbrenner (1969) describes modelling as the attempt to think, feel and act like another person, but it may result in exaggerating the characteristics of the model. He says that ". . . what is expected in modelling is not identity of elements but an analogy in pattern such that corresponding features, though differing in magnitude, occupy the same relative position in the total configuration."

A study by Harris (1974) demonstrated a major degree of modelling of students' attitudes on those of their clinical teachers, although it also showed that students entering medical school are already more similar in attitudes to clinical teachers than students entering training for a different profession. This study therefore confirms the effect of modelling, but serves to indicate that the initial behaviour of the students is also important in determining future attitudes. This concept is in agreement with the analysis that the observational learning of attitudes occurs as a result of classical conditioning. (Kanekar, 1976).

It is considered, however, that observational learning, as with any other form of learning, is rendered more effective if the student receives feedback and reinforcement as a result of his or her behaviour. The need for this is also emphasized in other sections of this paper as essential features of programmes designed to develop interpersonal relationship skills.

FEEDBACK AND REINFORCEMENT

Das (1969) reminds us that in animal experiments Thorndyke found reward to be more effective than punishment. With verbal reinforcement, however, reward and punishment seem to have the same effect. Social needs are especially prominent in learning situations where face to face contact exists, and social approval (reward) fulfils a social need. Estes (1969) states that, although people come to select experiences which lead to reward rather than those which do not, it cannot be concluded that there is a direct relationship between the occurrence of the reward and the establishment of a learned association between stimuli and responses.

In fact, a large proportion of the literature regards feedback as being more important than reinforcement. In order for feedback to be effective, Argyris (1970) suggests that the student must be open to learning. It should be noted how the student prefers to tackle problems and whether he or she deals openly with situations such as difficult issues and emotions. It is important to recognize whether the students evaluate each other, thus creating competition. The supervisor must also be open, and prepared to experiment with his or her own ideas and feelings, and must always communicate clearly without self-contradiction.

Warren (1976) summarizes a number of dimensions related to change of behaviour as a result of feedback. Of importance is the context of the feedback, whether it was imposed or solicited, its timing, whether it was concurrent with the performance or given afterwards, the feedback medium and instruments such as video or audiotape, rating scales or oral or written reports, the type of feedback, whether it was focused or general, objective or subjective, descriptive or evaluative, the source of the feedback, peers, patient, self, supervisor; its content, concerned with modifiable or unmodifiable behaviours. The type of student learning styles, expectations, anxiety, achievement motivation, self-esteem, is also significant.

Feedback is not only an important factor in improving performance, but also in contributing to student confidence. Confidence in one's ability may be enhanced by approbation, approval, reinforcement, acceptance, consistency, attentiveness and other signs of success if these are administered sincerely. (di Vesta & Thompson, 1970).

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